

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 12 1940
Registration District No. 3000

State File No. _____
Registrar's No. 11174

1. PLACE OF DEATH: 2
(a) County ST. LOUIS
(b) City or town ST. LOUIS
(c) Name of hospital or institution:
1923(R) FRANKLIN AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH ANDERSON MCKINNEY
3. (b) If veteran, name war ✓ 3. (c) Social Security No. NONE
4. Sex FEMALE 5. Color or race COL. 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive ✓ years _____
7. Birth date of deceased JAN. 24 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 25 ✓ hr. ✓ min.

9. Birthplace MACON MISS.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____
12. Name DAN HARRIS
13. Birthplace UNKNOWN (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (State or foreign country)

16. (a) Informant's own signature Mrs. Jona Allen
(b) Address 1923 Franklin Ave. Near 14
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-39 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director LOVE UND. CO. INC.
(b) Address 3103 WASHINGTON BLVD.
19. (a) DEC 20 1939 (Date received local registrar) (b) J. B. Black (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State MISSOURI (b) County ST. LOUIS
(c) City or town ST. LOUIS 21
(If outside city or town limits, write "RURAL")
(d) Street No. 1923(R) FRANKLIN AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ years _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 19 day Dec.
year 1939 hour 9 minute 55 M.
21. I hereby certify that I attended the deceased from Dec. 13 1939 to Dec 19 1939
that I last saw her alive on Dec 18 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration 3 Mo.
Due to myocarditis 1 yr.
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accidental, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. L. Moore (M. D. or other) _____
Address 1418 Franklin Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

W&M
W&M

Signed Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address. 3028 Dickson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.